State of Idaho Emergency Medical Services Bureau

Provider Application Form

Level Applied For: ☐ First Responder ☐ EMT-Basic ☐ Advanced EMT-A ($35.00 fee) ☐ EMT-Paramedic ($35.00 fee)

Type: ☐ Initial ☐ Recertification ($25.00 fee for AEMT-A and EMT-P) ☐ Reinstatement ☐ Reversion ☐ Ambulance Rating (complete back) ☐ Reciprocity

Applicant Information:

Social Security # ____ - ____ - ____ Date of Birth ____ / ____ / ____ Drivers License # _____ DL State ____

Name _____ Gender ☐ F ☐ M

Last Name First Name Middle Name/Initial

Mailing Address _____

City _____ State _____ Zip _____ County _____

Home Phone # _____ Work Phone # _____ Cell Phone # _____

E-Mail Address _____ Circle the highest level of education: GED High School Diploma College: 1 2 3 4 5 6 7 8

Affiliation:

Agency Name _____ Agency License # _____

Agency Chief/Director/President _____ _____

Signature Printed Name

Additional Licensed EMS Affiliations: _____

Check all circumstances in which you will use this certification: *Volunteer* *Career*

☐ True ☐ Full Time

☐ Compensated ☐ Part Time

Applicant Signature:

I hereby affirm the information herein is true and correct, and that I meet all requirements for EMS certification as established by the State of Idaho.

_____ _____

Signature of Applicant Date signed

For Bureau Use Only

Received in RO Complete

Received in C&L Complete

CHC Scan Date (PROV) _____

CHC Complete Date (FULL) _____

Course # _____

NR Written Date _____

NR Practical Date _____

Ambulance Rating (if AEMTA)

Date _____ Included ☐

Cert. Fee Rcvd Date_____

Approval Date/Initial _____

Entered into Database _____

_____

Date Sent to CO _____

Previous ID State Certification ☐

_____

First Responder/Basic

Test Date	Expiration
4/03-9/03	9/30/2006
10/03-3/04	3/31/2007
4/04-9/04	9/30/2007
10/04-3/05	3/31/2008
4/05-9/05	9/30/2008
10/05-3/06	3/31/2009
4/06-9/06	9/30/3009
10/06-3/07	3/31/2010
4/07-9/07	9/30/2010
10/07-3/08	3/31/2011
4/08-9/08	9/30/2011

Advanced, Intermediate and Paramedic

Test Date	Expiration
4/04-9/04	9/30/2006
10/04-3/05	3/31/2007
4/05-9/05	9/30/2007
10/05-3/06	3/31/2008
4/06-9/06	9/30/2008
10/06-3/07	3/31/2009
4/07-9/07	9/30/2009
10/07-3/08	3/31/2010
4/08-9/08	9/30/2010

Current EMS Certification and/or NR Registration Level:

☐ First Responder ☐ EMT Basic ☐ Advanced EMT (I-85) ☐ Intermediate (I-99) ☐ EMT Paramedic

Other State Level Certification _____

Attach legible copies of all current state EMS Certification and/or National Registry of EMT's registration card(s).

Out of State Certification Verification

Prerequisite to certification eligibility. Please Fill out and sign one (1) *Idaho Certification Verification Request* form for each state where a current EMS certification is held.

Certification History:

Please list all EMS certifications beginning with the most recent:

LEVEL	STATE	ISSUING AUTHORITY	EXPIRATION DATE

Have you ever been subject to disciplinary action regarding your EMS certification? O Yes O No

(If yes, attach a written explanation including the state and EMS authority that instituted the action.)

IDAHO CERTIFICATION VERIFICATION REQUEST

PAGE 1 OF THIS FORM MUST BE COMPLETED BY THE APPLICANT.

Authorization to release information to the IDAHO EMS BUREAU

NAME:_____
First Last M.I.

ALSO KNOWN AS: _____
Alias, Maiden or Nicknames

MAILING ADDRESS: _____
City State Zip

IDAHO EMS AGENCY OF PRIMARY AFFILIATION: _____

I hereby authorize the state of _____ EMS credentialing agency to furnish the information requested on Page 2 of this document.

_____ _____
Certification/License Number EMS Level

_____ _____
Social Security Number Date of Birth

The Idaho EMS Bureau thanks you for your timely response and participation in completing this form.

Applicant Signature	**Date**

Internal Use
R/O Date Recd_____
R/O Date Sent to C/O_____
C/O Date Request Sent _____
Date Returned _____
Date Evaluated _____
Applicant Notified _____

IDAHO DEPARTMENT OF HEALTH & WELFARE

IDAHO E·M·S

Revised 06 01 2006

APPLICANT NAME _____

APLLICANT DATE OF BIRTH_____ APPLICANT SS#_____

THIS FORM MUST BE COMPLETED BY THE STATE EMS CREDENTIALING AUTHORITY

1. STATUS OF CERTIFICATION/LICENSURE

EMS LEVEL: _____

CERTIFICATION / LICENSE #: _____

EXPIRATION DATE: _____

2. HAS YOUR STATE TAKEN ANY DISCIPLINARY ACTION AGAINST THIS PERSON RESULTING IN A SUSPENSION, PROBATION, REVOCATION OR DENIAL FOR EMS CERTIFICATION OR LICENSURE? ☐ **YES** ☐ **NO**

IF YES, PLEASE DESCRIBE (Use Attachment if needed) ;

_____
_____
_____
_____
_____
_____
_____

3. IS THIS INDIVIDUAL CURRENTLY UNDER INVESTIGATION BY YOUR AGENCY? ☐ **YES** ☐ **NO**

IF YES, UPON COMPLETION OF INVESTIGATION, PLEASE NOTIFY THE IDAHO EMS BUREAU OF THE OUTCOME AND ANY DISCIPLINARY ACTION.

I hereby certify that the above information is true and correct recorded by this office.

_____ _____

Signature Name (print)

_____

Title

_____

Agency Name

_____

Date

State Board or Seal

Please fax Page 2 to 208-334-4015 or mail to:
Idaho EMS Bureau
590 W. Washington St.
Boise, ID 83702
Attn: Credentialing Manager

IDAHO DEPARTMENT OF HEALTH & WELFARE

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